SECTION 11

11000 - RESIDENTIAL CARE ASSISTANCE PROGRAM (RCAP)

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11000 RESIDENTIAL CARE ASSISTANCE PROGRAM (RCAP) PURPOSE

(a) The Residential Care Assistance Program (RCAP) is a state funded program that is composed of two parts; Room and Board Assistance (RBA) and Assistance to Residents in County Homes (ARCH).

(b) RBA provides financial assistance contingent on availability of funds, to eligible persons who reside in county owned and operated residential facilities or Christian Science facilities certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Incorporated.[1]

(c) ARCH provides financial assistance contingent on availability of funds, to eligible persons who reside in county owned and operated residential facilities.[2]

11001 CLIENT ELIGIBILITY

(a) The RCAP applicant must meet Indiana residency requirements by being a resident or potential resident of a facility contracted by FSSA DA to provide RCAP services.

(b) The RCAP applicant must also meet at least one of the following categorical eligibility requirements[3]:

(1) AGED - must be 65 years of age or older;

(2) BLIND - The degree of blindness is determined by the FSSA Medical Review Team (MRT) based upon a visual exam, unless both eyes are missing, applicant receives SSI based upon blindness, or eligibility has previously been established under Medicaid Blind (MA B category) The client also must be at least eighteen (18) years of age; or

(3) DISABLED – Disability is determined by the Medical Review Team (MRT) based upon social and medical information. The client also must be at least eighteen (18) years of age. Physical exam is required unless:

(A) the applicant is receiving SSI based upon disability;

(B) the MRT has previously established eligibility and required no progress report; or

(4) CURRENT MEDICAID FOR THE BLIND (MA D) recipient.

(c) The RCAP applicant has the responsibility of furnishing all information necessary to determine eligibility. The DFR caseworker has the responsibility of verifying all eligibility requirements.

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[1] Indiana Code, 12-10-6-2.1
[2] Indiana Code, 12-10-6-1
[3] Indiana Code, 12-10-6-1(a)1)(2)

11001.1 FINANCIAL ELIGIBILITY

(a) Resources:

(1) All resources must be verified.

(2) All countable resources must be available[4] to the client(s).

(3) For RCAP eligibility determination the resources of the applicant/recipient (A/R) AND the spouse if they are both living in the RCAP facility are counted.

(4) For RCAP eligibility determination, the resources owned solely by the spouse not in the RCAP facility are not counted. (For RCAP related Medicaid (MAR) the resources of the applicant/ recipient AND the resources of the spouse at home are to be counted).

(5) Current month's income is not counted as a resource.

(6) A resource remains a resource even after liquidation.

(7) Resource limitation for a single A/R is $1,500 and $2,250 for a couple both living in the facility.

(8) Equity value of all non-exempt personal property is counted.

(9) Examples of personal property are:

(A) cash;

(B) contents of a safety deposit box;

(C) stocks/bonds;

(D) bank accounts;

(E) cash surrender value of life insurance owned by the A/R and his/her spouse who also lives in the RCAP facility;

(F) automobiles; and

(G) recreational vehicles.

(10) Some personal property is exempt. Examples of exempt personal property are:

(A) one automobile needed for employment, medical treatment, or modified for a handicapped person;

[4] "Availability" means the owner of a resource has the ability to liquidate or dispose of the resources. A resource can be solely or jointly owned. See ICES Program Policy Manual, Section 2605.10.00 and 2605.10.05 for more information.

(B) irrevocable burial trust;

(C) cash surrender value of life insurance policies with total face value of $1,400 or less if provision has been made for payment of the funeral expenses of the A/R from the proceeds of the insurance, the $1,400 limitations is reduced by any amount in an irrevocable burial trust or an irrevocable prepaid funeral agreement;

(D) all personal effects;

(E) personal property used to produce income (if the income is more than the expenses); and

(F) proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss or theft of exempt real or personal property for a period of no more than 9 months.

(11) Real property is considered based upon whether or not it is exempt. Examples of exempt real property are:

(A) the home if it is the residence of the A/R's spouse, child(ren) under 18; or child(ren) over 18 if blind/disabled;

(B) income producing property (if income is greater than expenses of ownership); and

(C) burial spaces.

(12) Non-exempt real property must be offered for rent or sale at a fair market value (FMV).

(13) Excess resources on the first day of the month render an A/R ineligible for the whole month.

(14) A life care contract may render an individual ineligible for RCAP unless the facility can prove that it is no longer able to fulfill the legal responsibilities under the contract.

(b) Income:

(1) Monthly income is considered in the month it is received. (Exception: When a direct deposited income check is received early, the amount of the direct deposit must be counted for the month it was intended.)

(2) Fluctuating income is to be averaged on a three month basis.

(3) Income received less often than monthly is to be prorated by the number of months to be covered.

(4) Regular income is to be converted to a monthly amount as follows:

(A) Weekly income is multiplied by 4.3;

(B) Bi-weekly income is multiplied by 2.15; and

(C) Semi-monthly income is multiplied by 2.

(5) Unearned income is income not received from an employer, such as SSI (Supplemental Security Income), RSDI (Retirement, Survivors, and Disability Insurance), pensions and other types of income. Gross income is counted.

(6) Earned income is payment received in cash from an employer; such as wages, salaries or commissions, or income from rental property.

(7) Allowable deductions from earned income are as follows:

(A) sixteen dollars for each employed person (not per job);

(B) all mandatory payroll deductions;

(C) transportation expense to and from work;

(D) mandatory meals; and

(E) any other mandatory expenses.

(8) For sheltered workshop earnings, divide the net income by two (after allowing applicable expenses).

(9) Refer to ICES Program Policy Manual (IPPM), Section 3420.00 regarding the treatment of rental income.

(10) Disregarded income includes:

(A) educational funds designated for tuition, books, and fees;

(B) tax refunds; and

(C) tax liabilities for state and local income taxes;

(D) Holocaust victim's settlement payment.[5]

(11) SSI is not exempt or disregarded as income for an RCAP A/R.

(d) Appeals – If the applicant/ recipient is not satisfied, an appeal may be requested. Refer to *Hearings and Appeals Process - Section 3000* for appeal procedures.

[5] Indiana Code, 12-10-6-1(f) Added 4/10/06

11002 THE ROLE OF FSSA DA

(a) FSSA DA will assign a person to the RCAP as a coordinator.

(b) The RCAP Coordinator will:

(1) develop policies in coordination with all stakeholders to include other State staff and FSSA Division of Family Resources;

(2) provide guidance and training as needed;

(3) receive and attempt to resolve problems/ complaints in coordination with other stakeholders;

(4) monitor all aspects of the program to include timeliness and accuracy of the intake/eligibility process which includes taking periodic random samples of cases submitted by DFR caseworkers to verify timeliness and accuracy, and contacting DFR caseworkers to provide technical advice when inaccurate or incomplete documentation is received by FSSA Claims Management;

(5) coordinate problem solving with the State office of DFR;

(6) review Housing with Services Establishments Disclosure form submission;

(7) develop a monitoring tool in coordination with DFR staff and all other stakeholders;

(8) make on-site monitoring visits; and

(9) utilize written and face-to-face interviews to determine client satisfaction with services.

11003 CASE PROCESSING

(a) Case processing is completed by the DFR caseworker in the counties where RBA and/or ARCH facilities are located or in the county where the applicant resides.

(b) Applications must be processed and the State Form 5B *Assistance to Residents in County Homes/Room and Board Assistance Budget and Recommendation* must be completed and submitted to FSSA claims processing within twenty working days from the date of receipt of all requested documentation.

(c) Acceptance and processing of RCAP applications includes the following steps:

(1) The DFR caseworker shall gather documentation verifying the applicant meets the eligibility criteria;

(2) If found eligible, the client will be placed on the RCAP, if state funding is

available;

(3) If found eligible and funding for additional slots is not available, the applicant shall be advised to check again after the beginning of the next State Fiscal Year. RCAP does not keep a waiting or inquiry list.

(d) All applications must be complete and must be signed and dated by the applicant or someone acting on their behalf. If the application is signed in the presence of a DFR caseworker, the application is valid of that date. If the application is not signed in the presence of the caseworker, the signature must be notarized. In such cases, the valid date is the date the application was notarized.

(e) During the application process, the following shall be completed:

(1) an applicant must inform the DFR caseworker of their choice of facility and the facility's willingness to accept the applicant as a resident. If the applicant does not have a facility that will accept the applicant, no application will be taken.

(2) potential applicants are to complete an Application for the Residential Care Assistance Program at their local DFR.

(3) the DFR caseworker will determine eligibility of applicants for RCAP and Medicaid program or State Medical Assistance, if applicant will be entering a County Home.

(4) when an applicant has been determined eligible for RCAP, the DFR caseworker will send the recommendation form and budget recommendation (see appendix) to FSSA Claims Management. The DFR caseworker will enroll the applicant in the Medicaid program pending RCAP or State Medical Assistance, if the applicant will be entering a county home.

(5) FSSA Claims Management will send a Certificate of Action indicating the eligibility date of the applicant based on the date of application, to the respective DFR, the FSSA Division of Aging (FSSA DA) and two copies to the facility, one of which is to be given to the resident.

(f) Denials/Terminations

(1) When an applicant is denied or terminated from the RCAP by the DFR, a Budget Recommendation Form will be sent to the FSSA Claims Management. After appropriate action, FSSA Claims Management will send a Certificate of Action indicating the change to the respective DFR and two copies to the respective facility, one of which is to be given to the resident.

(g) Continuing Program Eligibility

(1) The DFR caseworker is responsible for determining that each resident continues to meet all eligibility requirements. There must be a re-determination completed annually. The DFR caseworker will send an annual Recommendation Form to FSSA Claims Management. FSSA Claims Management will send a certificate of action indicating any changes to the respective DFR, the FSSA DA

and two copies to the respective facility, one of which is to be given to the resident.

(h) Ceasing the Acceptance of New Applications

(1) The FSSA DA will monitor the RCAP budget to determine if funds are available to support new applicants.

(2) If such a level of encumbrance is reached that warrants suspension of accepting new RCAP applications, the FSSA DA will send a notice to all DFR to discontinue taking new applications. The DFR will post this notice in a public place in their offices.

(3) The FSSA DA will send a copy of the notice to discontinue taking applications to all RCAP providers.

(4) All residents currently enrolled will continue to receive RCAP funding.

(5) Any applications that are pending at DFR or FSSA Claims Management, prior to the effective date of the notice to discontinue, will be processed (Prior to the effective date means by the close of business on the day before the date indicated on the Termination Notice)

(i) Resumption of Accepting and Processing RCAP Applications

(1) If FSSA DA determines that funds are available to re-open the application process, a notice will be sent to all DFR informing them that they are to resume accepting and processing new applications for RCAP. The DFR will post this notice in a public place in their office.

(2) The FSSA DA will send a copy of the notice to all RCAP Providers.

(j) Case Numbering

(1) The RBA or ARCH case number is separate and distinct from the Medicaid number. Each client will have an RBA or Arch number in addition to his/her Medicaid number.

(2) Each Case Number must consists of ten symbols;

(A) A 2 letter prefix that identifies the category of service;

MA = RBA Aged	MD = RBA Disabled	MB = RBA Blind
RA = ARCH	RD = ARCH Disabled	RB = ARCH Blind

(B) a two digit county number; and

(C) a six digit case number

(3) Case number examples:

RA49001234 = ARCH aged client, Marion County, case number 1234
MB01000312 = RBA blind client, Adams County, case number 312

(4) Case numbers must be unique to the individual case. The DFR must assure that case numbers within each of the two categories of service (ARCH and RBA) remain separate and in numerical order, i.e.:

(5) Examples: ARCH Cases 123, 124, 125
RBA Cases 123, 124, 125

11003.1 BUDGETING

(a) General Explanations:

(1) Personal Needs Allowance (PNA)

(A) Each RCAP client is allowed to keep from their monthly gross income an amount specified in state law (IC 12-10-6-1) to meet their monthly personal needs (Personal Needs Allowance or PNA). The balance of their income (liability) goes to the facility. In cases where the individual has no income, the state provides the required PNA amount to the individual.

(B) Current PNA amount as established by the legislature is fifty-two dollars.[6]

(2) Supplemental Security Income (SSI)

(A) When an individual who receives SSI in the community enters an RBA facility, the individual will continue to receive SSI benefits.

(B) When the SSI recipient moves into an ARCH facility the Social Security Administration (SSA) totally discontinues the SSI benefits.

(b) Budgeting Income of Single RCAP Recipient includes the following steps:

(1) Determine countable income;

(2) Subtract the PNA;

(3) The unrounded remainder is the liability amount.

(4) Subtract the RCAP rate from the liability. The RCAP monthly rate is computed by multiplying the facility's daily rate by 365 and dividing by 12 months equaling the monthly per diem. The RBA per diem rate is $39.35/ day. The ARCH per diem rate is $27.00/day.

(5) If the resultant amount is a deficit, this will be the amount of the RBA award.

[6] Indiana Code, 12-10-6-1(d)(1)

(6) If there is a surplus, the applicant is ineligible RCAP.

(7) If there is a surplus for a current recipient, due to an increase in income, the individual is eligible only if the surplus does not exceed the facility's private rate and the recipient is willing to pay the excess income to the facility.

(8) The liability for the RCAP facility is not a Medicaid liability and is not computed by ICES or entered into the system. It is computed manually by the caseworker.

(c) Budgeting Income for Applicant and Spouse.

(1) Both applicant and spouse must be living in the RCAP facility.

(2) Consider each spouse's eligibility as directed in the budgeting procedure for a single applicant.

(3) If one spouse is eligible and one is ineligible, all or part of the ineligible spouse's income is considered to be available to the other spouse.

(4) Determine the ineligible, spouse's average monthly medical expenses.

(5) Subtract these expenses from his/her surplus income.

(6) The result is the amount of available (deemed) income for the other spouse.

(7) Add the amount of deemed income to the eligible spouse liability.

(8) If the eligible spouse's liability does not equal or exceed the facility's RCAP rate, the case is approved.

(9) If the eligible spouse is a recipient, she/he remains eligible as long as the liability does not equal or exceed the private pay rate.

(d) Budgeting For Partial Month of Admission.

(1) If an applicant enters the RCAP facility on a day other than the first day of the month, eligibility for that month is based upon the RCAP daily rate multiplied by the number of days remaining in the month. The current licensed facility or RBA rate is $39.35/day and ARCH is $27.00/day.

(e) Special Circumstances

(1) When a Medicaid (Title XIX) recipient has a spend-down and enters an RCAP facility after the first day of the month, the Medicaid eligibility is based on the RCAP eligibility.

(2) RCAP per diem cannot be used to meet Medicaid Spend-Down.

(3) RCAP clients may not pay a Spend-down to be eligible for the RCAP program

to meet spend-down.

(4) An RCAP recipient who leaves the RCAP facility and goes to a nursing home is expected to pay the RCAP facility for the days he/she resides there.

(5) Nursing home liability should be computed for no later than the second subsequent month.

(6) An RCAP recipient who leaves the RCAP facility and returns to the community is expected to pay the per diem charges up to the liability for the days he/she resided in the RCAP facility.

(7) An RCAP recipient who leaves the RCAP facility and returns to the community is expected to pay the per diem charges up to the liability for the days the individual resided in the RCAP facility.

11004 PROVIDER INFORMATION

(a) To be a RCAP Provider, a facility must be:

(1) licensed by the State Department of Health as a residential care facility under IC 16-28; or

(2) an accredited Christian Science facility; or

(3) a facility owned and operated by an Indiana County Government office; and

(4) have a contractual agreement with the FSSA DA to provide services.

(b) An accredited Christian Science facility or a facility owned and operated by an Indiana County Government office must:

(1) meet all applicable fire safety codes and receive regular fire safety inspections from the State Fire Marshall's office or local fire department (and)

(2) have regular health inspections by the appropriate local entity.

(c) All RCAP Providers are classified as "housing with services establishments" and must file the "*Disclosure For Housing With Services Establishments"* form annually in accordance with Indiana Code 12 -10-15. Housing with services establishments include any freestanding facilities and/ or part of a campus or complex (Independent living, nursing facility, apartment complex, hospital and/or continuing care facility. If a disclosure form is not submitted, the business shall not):

(1) enter into or extend the term of the contract with an individual to reside in a housing with services establishment; or

(2) use the term "assisted living" to describe the housing with services establishment's services and operations to the public. See the form titled - *Disclosure For Housing With Services Establishments* - which can be accessed on the FSSA website. The web address is *http://www.in.gov/fssa.*

11004.1 PROVIDER SERVICES

(a) An RCAP Provider must provide room and board, housekeeping, laundry and minimal supervision to RCAP clients. Also, the following requirements must be met:

(1) Facilities must be clean and as homelike as possible;

(2) Residents will have clean linens and clothing available at all times; and

(3) Supervision will be conducted in such a way as to maximize a client's potential for autonomy and decision making.

(b) Client Intake Option:

(1) RCAP providers may assist applicants in completing an application for RCAP Services. The applications will be processed by the local DFR office under the following circumstances:

(A) The application is signed and dated by the applicant in the presence of a notary public;

(B) There are RCAP slot vacancies available. (*See Section 11003 (g) - Ceasing Acceptance of Applications*); and

(C) The application is received in the DFR office within 10 working days of the date it was signed and notarized.

(c) Required Administrative Activities

(1) RCAP Providers are required to notify the DFR office of any change in a client's RCAP status within 10 days of change. RCAP Status changes include:

(A) change in income;

(B) no longer eligible for RCAP;

(C) moved from the facility;

(D) voluntarily withdrew from program;

(E) hospital stay exceeding number of paid days available;

(F) Short-term nursing home stay; and

(G) Death (Always include date of death).

(2) Follow-up to application change of status report:

(A) The RCAP provider should follow-up on any application or change of

status report if there has been no resulting action after 45 days. First contact should be with the DFR caseworker assigned to work with the facility. Should further action be needed, the FSSA DA RCAP Program Coordinator should be contacted.

11004.2 REIMBURSEMENT

(a) Reimbursement for services established by FSSA DA (IC12-10-6-1). The current rate is $39.35/day for licensed facilities. The current rate for unlicensed facilities is $27.00/day.

(b) Payment to an RCAP provider will not exceed lower of the maximum rate established by FSSA DA or the facilities private pay rate.

(c) See Section 11003(a) for payment for client personal needs allowance.

11004.3 PAYMENT FOR PROVIDER SERVICES

(a) Payment is made on a per client, per day basis.

(b) Payment will be made to hold a place for a RCAP client under the following circumstances for the maximum time indicated:

(1) Hospital stay - 15 days paid per visit.

(2) Vacation days - 18 days paid every 6 months (Based on the RCAP effective date). Vacation days may be used for extended hospital or rehab stays. A change of RCAP status form must be completed and sent to DFR by the provider.

(3) Rehabilitation days - 15 days non-paid per visit.

11003.4 CLAIMS MANAGEMENT PROCESS

(a) Family and Social Services Administration (FSSA) Claims Management (CM) receives the application packet or updating documentation with case information, the DFR caseworker's signature as verifying verification of the information. (Note: all payments are based on information submitted by caseworkers.)

(b) If the applicant has been determined not eligible, or another adverse action has been determined, FSSA Claims Management sends a Certificate of Action (COA) denying services to the applicant, the chosen provider and the DFR caseworker. The mailing will include a notice of the appeal procedure.

(1) If the applicant has been determined eligible or another positive action has been determined and all forms are determined complete and correct by the FSSA, Claims Management enters the date in the claims management data

system (CMS) and sends a Certificate of Action to the applicant, the chosen provider, the DFR Caseworker stating date of client's eligibility.
(2) Enter information from the packet into the Claims Management Data System (CMS).

(3) FSSA Claims Management sends information necessary to authorize payment for services and to authorize payment of appropriate PNA to clients to the State Auditor's Office monthly. The State Auditor's office cuts the checks and returns them to Claims Management.

(4) Payment is issued monthly, by the State Auditor's Office.

(c) Handling of Incomplete or Incorrect Information submitted by the DFR caseworker:

(1) When Claims Management receives incomplete or questionable information from a DFR Caseworker or when the information conflicts with client or provider information already in the CMS; Claims Management will forward the information to FSSA DA